NOTICE OF INDEPENDENT REVIEW DECISION

December 5, 2002

RE: MDR Tracking #: M2-03-0326-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The __ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to __ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 46 year old male sustained a work-related injury on ___ when he injured his lower back. The patient is status post lumbar discectomy, laminectomy, and lumbar fusion on 12/27/00. On 05/02/02 the patient underwent a lumbosacral epidural decompression neuroplasty with chemical and mechanical adhesiolysis. The patient is experiencing an increase in low back pain and lower extremity pain and numbness in his legs. The treating physician has recommended that the patient undergo a repeat left percutaneous lumbosacral decompression.

Requested Service(s)

Left percutaneous lumbosacral decompression.

Decision

It is determined that the left percutaneous lumbosacral decompression is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Epidural neuroplasty (lysis of adhesions) is a common pain management procedure in patients with failed back syndrome and epidural fibrosis. This patient has had spine surgery and was noted to have epidural fibrosis on epidurogram. He has not responded to conservative care. His pain is described as 8 on a scale of 1-10. Most textbooks (pain management) include neuroplasty in their algorithms of failed back surgery syndrome patients; e.g. Anderson, Susan, "A Rationale for the Treatment Algorithm of Failed Back Surgery Syndrome", Current Review of Pain 2000. Vol. 4,

p395-406. Studies have shown an association between epidural scar tissue and recurrent radicular pain after surgery as referenced in; Ross, Jeffrey et al, "Association Between Peridural Scar and Recurrent Radicular Pain", Neurosurgery, Vol. 38, No. 4, 1996, p855-863. Epidural neuroplasty is a technique to disrupt the ground substance in the epidural adhesions. 49% of patients have been shown to have decreased pain as compared to controls as referenced in; Pain Digest 1999, 9:91-97-102. This patient received 2 months relief from his first injection and results have shown that he should have an even longer period of relief after the second injection as referenced in; Manchikanti L, et al, "Role of Adhesiolysis and Hypertonic Saline Neurolysis in Management of Low Back Pain", Pain Digest 1999, 9:91-96.

Therefore, it is determined that the left percutaneous lumbosacral decompression is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).